MINOR DEPENDENT INTAKE QUESTIONNAIRE

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

EMPLOYEE ASSISTANCE PROGRAM

PLEASE PRINT

Office Use Only	
Client # :	Date :

LAST NAME FIRST NAME M.I.

Sex: ☐ Male ☐ Female Last 4 digits of Social Security #_____

D.O.B._____ Age: _____

Contact by mail: YES ☐ NO ☐

Address Street City Zip

Home phone cell/pager

Ethnicity: _____

Education

School Name

Grade

Address Street City Zip

Parent/Guardian Name Parent/Guardian work phone

May we contact at work? ☐ YES ☐ NO

Health Insurance Information

☐ Aetna ☐ HMO ☐ PPO

Secondary Insurance: _____

Social Security/Policy #: _____

School Board Employee Name: _____

How were you referred: _____

Clinical Information

Previous therapy? ☐ YES ☐ NO

If yes, when/how long _____

Suicidal/Homicidal thoughts/ideation?
Current ☐ YES ☐ NO
Past ☐ YES ☐ NO

Suicidal/Homicidal Plans? Current ☐ YES ☐ NO
Past ☐ YES ☐ NO

Current Medical Conditions

Under Psychiatric care? ☐ YES ☐ NO

Current medical conditions? ☐ YES ☐ NO

Medications ☐ YES ☐ NO

_____

(if yes, what)

Substance Use

Alcohol ☐ YES ☐ NO _____wkly average

Smoke ☐ YES ☐ NO _____wkly average

Recreational drugs ☐ YES ☐ NO _____wkly average

Type (s) of recreational drugs: _____

Have you ever felt you should cut down on drinking/drug use? ☐ YES ☐ NO

Do you get annoyed by comments people make about your drinking/drug use? ☐ YES ☐ NO

What are the times of day/days of the week that you drink/use drugs? _____

Family History

Mother Living ☐ YES ☐ NO

Father Living ☐ YES ☐ NO

If no, cause of death: _____

# of sisters_____ # of brothers _____

Birth placement: ☐ Oldest ☐ Middle ☐ Youngest

Is there a history of abuse? ☐ Physical ☐ Verbal ☐ Emotional ☐ Sexual

Check ones that apply to your current feelings

☐ sad	☐ overwhelmed	☐ frustrated	☐ optimistic
☐ lonely	☐ guilty	☐ confused	☐ drained
☐ nervous	☐ helpless	☐ numb	☐ bored
☐ irritable	☐ hopeless	☐ distrustful	☐ fearful
☐ angry	☐ grief	☐ happy	

My overall sense of emotional strength is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

I understand that once I am assigned a therapist for ongoing services I will be responsible for paying any co-payments or deductibles in accordance with my insurance contract.

_____

Client Signature

_____

Parent/Guardian Signature

Thank you for your cooperation.